State Trauma Advisory Board
Retreat
November 14, 2003

OVERVIEW

Introduction

In January 2002 the Arizona EMS/Trauma Systems Plan was approved and adopted. This was a significant step in the formalization of the EMS and Trauma System as a necessary system component of the overall health care delivery in Arizona. Many individuals, committees, and agencies contributed many hours towards the planning, development and incremental implementation to building a comprehensive system. To follow this major accomplishment of the plan as a blueprint, steps in adopting formal legislation that will allow putting the major components in place to function, as a system will be critical. For these reasons, decision was made by the State Trauma Advisory Board (STAB) to hold discussions to determine the priorities and the next logical steps in implementing the EMS/Trauma Systems Plan. The following information describes the activities and decisions of the STAB Retreat.

Participants: Members of STAB
Judi Crume, Chief, BEMS
Suzy Baulch, Administrator, Trauma/Prevention Systems
Gail Cooper, Guest Facilitator
Dr. Brent Eastman, Guest Presenter
Dr. Terrence Lofton, JC Lincoln Hospital
Tracy Edwards, RN, JC Lincoln Hospital
Regional EMS Managers and other BEMS staff

Round-table introductions were made followed by an overview of the day's activities by Dr. Sucher. Dr. Cathy Eden, Director of ADHS, welcomed the group and expressed appreciation for the time and energy given for the efforts towards trauma systems development.

To open the day's activities, Judi Crume provided a brief background of the incremental steps of the trauma systems progress and the current status. Rose Conner, Assistant Director, Public Health Services, provided a copy of the proposed legislation that has been approved by the Director of the Department of Health Services as a public health initiative and subsequent approval by the Governor as supported legislation. Suzy Baulch presented the priority goals/objectives, achievement needs of the Arizona Trauma System to set the stage for the meeting deliberations.

Gail Cooper, EMS/Trauma Systems consultant from San Diego, was introduced as the facilitator for the remainder of the meeting. The following issues were included in the group discussions:

- Differences in the verification/designation trauma center process.
  - Verification (facility driver) accommodated by an out-of-area site team reviewers, usually offered by the American College of Surgeons or other contract group.
  - Designation (system driver) can only be assigned by a formally legislative recognized lead agency, usually a regulatory body.

Discussion covered the various processes, but it was pointed out that the Plan allows the verification by ACS to meet the requirements for designation. It was recommended the process for verification/designation be assigned to be written. There would have to be an application, review team of two surgeons and/or up to five multidisciplinary members depending upon the needs of the system.

- Designation Authority

  Decision would have to be made on the process that could include:
  - application: report from American College of Surgeons
  - written agreement between facility and State
    * responsibilities
    * integration of trauma centers into statewide system
    * commitment to serve the system
    * outreach with education
    * trauma funding should be made to all levels in the system
    * time period of designation

- Regional Resources and Trauma Center Needs

  Comprehensive analysis needs to be done to show where the resources are on a statewide basis to include:
  - prehospital providers
  - hospitals
  - resources within the hospitals
  - populations
  - trauma patient transport
  - field trauma triage protocols
  - mutual agreements

  Decision was made to review the current regional assessments and map out what resources have been identified. It was pointed out that population numbers and levels of services available will be critical in planning the system. Decisions and standards setting can be made on the information and data collected.

- Data Sources
  - Good data result in good decisions and helps to set good standards. Reasons for collecting data are for cost-effective prevention programs, monitoring quality of care, setting baselines, preventable/non-preventable death rates and funding.
  - Data may be derived from trauma registries, ED discharge data, hospital discharge data, medical examiner, death listed in vital records, crash records, CODES project.
  - What kinds of data are required to be able to make decisions on enhancing the system?
    * Prehospital data - for time to definitive care to include response time, scene time, appropriate identification of major trauma victim, treatment, and transport time.
    * Hospital data – for time of arrival, availability of surgeons and other subspecialties, appropriate resuscitations, complications, length of hospital stay, procedures performed, severity of injuries, patient outcome, over/under triage rate.
    * Dead on Scene – prehospital and/or medical examiners data.

- STAB's Role/Responsibilities
  STAB has fulfilled its role as written in law, that of developing and implementing the EMS/Trauma Systems Plan, and now there is the need to reflect new responsibilities. Some responsibilities recommended are:
  - advise Director of ADHS
  - continued implementation of plan
  - review of standards
  - designation process
  - analysis of data
  - policy development
  - system changes
  - system improvement performance

Resolution of Meeting:

Decision was made to appoint four (4) work groups as follows:

1) Verification/Designation Work Group
   To recommend types of verification and process for designation and de-designation. Do not be concerned with the (e)essential or (d)desired elements at this point.

   Time Period: 6 months → MAY 2004

   CHAIR - Dr. John Porter
   CO-CHAIR Ingrid Bachtel, RN

2) Resources Assessment and Needs Work Group
   Do analysis of Needs Assessment for Northern, Central, Western, and Southeast Regions. Based on analysis, identify gaps in the system (acute care hospitals, access to care, physicians, specialists, nurses, prehospital levels of care, ambulance services, aero medical services).

   Time Period: 4 months → MARCH 2004
   (extend if information unavailable)

   CHAIR - Dr. Scott Petersen
   CO-CHAIR Dr. Stewart Hamilton

3) Data Resources/Collection Work Group
   Determine what trauma data is needed. Identify data sources and potential linkage of those resources. Research types of reports/data that are available from Vital Records, ED Discharge Data, Hospital Discharge Data, and Medical Examiner. Review status of Central Trauma Registry and reports available. Do SWAT analysis of data resources and make recommendation for a comprehensive data collection program.

   Time Period: 6 months → MAY 2004

   CHAIR - Dan Judkins, RN
   CO-CHAIR Bill Ashland, RN

4) STAB Role and Responsibilities Work Group
Identify Mission/Vision and define new role and responsibilities. Should reflect input from broad membership.

Time Period: 1 month → JANUARY 2004

CHAIR - Dr. Michel Sucher

TIME TABLES WILL BE CREATED TO MONITOR PROGRESS TO COMPLETION.

Special Presentation:
Dr. Brent Eastman, an active member of the American College of Surgery. and Trauma Medical Director for Sharp Memorial Medical Center, an ACS verified Level II trauma center, reported on the ACS Consultation Program for Trauma Systems. Dr. Eastman described the components that are included in the review: Mission; Goals; Administration of the System; Operational component; and the Clinical aspect of the System. The program was developed in 1997, and has reviewed 6 state systems, with several more scheduled. The cost is about $35,000. He emphasized that there are no "pass/fail" but is truly a consultation review to help states improve their systems by having a documented process.

Additional Notes
Ms. Cooper reported on the upcoming revision of the State Model Plan adopted by HRSA in 1990. The major change will be the adaptation of Public Health Model for trauma systems planning and implementation. This approach includes: assessment (what is the issue); policy development (formulating around the issue); and evaluation (quality improvement). Many of these steps are used in trauma systems planning, but this revision will formalize the approach.